AUTHORITY: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

SOURCE: 45 FR 22937, Apr. 4, 1980, unless otherwise noted.

Subpart A—General Provisions

§ 489.1 Statutory basis.

This part implements section 1866 of the Social Security Act. Section 1866 specifies the terms of provider agreements, the grounds for terminating a provider agreement, the circumstances under which payment for new admissions may be denied, and the circumstances under which payment may be withheld for failure to make timely utilization review. The following other sections of that Act are also pertinent.

(a) Section 1861 defines the services covered under Medicare and the providers that may be reimbursed for furnishing those services.

(b) Section 1864 provides for the use of State survey agencies to ascertain whether certain entities meet the conditions of participation.

(c) Section 1871 authorizes the Secretary to prescribe regulations for the administration of the Medicare program.

(d) Although section 1866 of the Act speaks only to providers and provider agreements, the effective date rules in this part are made applicable also to the approval of suppliers that meet the requirements specified in § 489.13.

(e) Section 1861(o)(7) of the Act requires each HHA to provide CMS with a surety bond.

[45 FR 22937, Apr. 4, 1980, as amended at 51 FR 24492, July 3, 1986; 62 FR 43936, Aug. 18, 1997; 63 FR 312, Jan. 5, 1998]

§ 489.2 Scope of part.

(a) Subpart A of this part sets forth the basic requirements for submittal

and acceptance of a provider agreement under Medicare. Subpart B of this part specifies the basic commitments and limitations that the provider must agree to as part of an agreement to provide services. Subpart C specifies the limitations on allowable charges to beneficiaries for deductibles, coinsurance, copayments, blood, and services that must be part of the provider agreement. Subpart D of this part specifies how incorrect collections are to be handled. Subpart F sets forth the circumstances and procedures for denial of payments for new admissions and for withholding of payment as an alternative to termination of a provider agreement.

(b) The following providers are subject to the provisions of this part:

(1) Hospitals.

(2) Skilled nursing facilities (SNFs).

(3) Home health agencies (HHAs).

(4) Clinics, rehabilitation agencies, and public health agencies.

(5) Comprehensive outpatient rehabilitation facilities (CORFs).

(6) Hospices.

(7) Critical access hospital (CAHs).

(8) Community mental health centers (CMHCs).

(9) Religious nonmedical health care institutions (RNHCIs).

(c)(1) Clinics, rehabilitation agencies, and public health agencies may enter into provider agreements only for furnishing outpatient physical therapy, and speech pathology services.

(2) CMHCs may enter into provider agreements only to furnish partial hospitalization services.

[45 FR 22937, Apr. 4, 1980, as amended at 47 FR 56297, Dec. 15, 1982; 48 FR 56036, Dec. 15, 1983; 51 FR 24492, July 3, 1986; 58 FR 30676, May 26, 1993; 59 FR 6578, Feb. 11, 1994; 62 FR 46037, Aug. 29, 1997; 68 FR 66720, Nov. 28, 2003]

§489.3 Definitions.

For purposes of this part—

Immediate jeopardy means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

Physician-owned hospital means any participating hospital (as defined in §489.24) in which a physician, or an immediate family member of a physician (as defined in §411.351 of this chapter), has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. This definition does not include a hospital with physician ownership or investment interests that satisfy the requirements at §411.356(a) or (b) of this chapter.

Provider agreement means an agreement between CMS and one of the providers specified in §489.2(b) to provide services to Medicare beneficiaries and to comply with the requirements of section 1866 of the Act.

[48 FR 39837, Sept. 1, 1983, as amended at 51 FR 24492, July 3, 1986; 54 FR 5373, Feb. 2, 1989; 59 FR 56250, Nov. 10, 1994; 60 FR 50119, Sept. 28, 1995; 72 FR 47412, Aug. 22, 2007; 73 FR 48757, Aug. 19, 2008]

§489.10 Basic requirements.

(a) Any of the providers specified in §489.2 may request participation in Medicare. In order to be accepted, it must meet the conditions of participation or requirements (for SNFs) set forth in this section and elsewhere in this chapter. The RNHCIs must meet the conditions for coverage, conditions for participation and the requirements set forth in this section and elsewhere in this chapter.

(b) In order to participate in the Medicare program, the provider must meet the applicable civil rights requirements of:

(1) Title VI of the Civil Rights Act of 1964, as implemented by 45 CFR part 80, which provides that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any program or activity receiving Federal financial assistance (section 601);

(2) Section 504 of the Rehabilitation Act of 1973, as implemented by 45 CFR part 84, which provides that no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination under any program or activity receiving Federal financial assistance;